

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL**  
FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:

9 5 — 1 5

2. STATE:

Kansas

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL  
SECURITY ACT (MEDICAID)

Medicaid

TO: REGIONAL ADMINISTRATOR  
HEALTH CARE FINANCING ADMINISTRATION  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

July 1, 1995

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR 447.201

7. FEDERAL BUDGET IMPACT:

a. FFY 95 \$ 3,750,000b. FFY 96 \$ 11,250,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

See Attached

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  
OR ATTACHMENT (If Applicable):

See Attached

10. SUBJECT OF AMENDMENT:

Nursing Facility Methods and Standards for Establishing Payment Rates

11. GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL☒ OTHER, AS SPECIFIED:

Janet Schalansky is the Governor's designee.

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:

Janet Schalansky

14. TITLE:

Deputy Secretary

15. DATE SUBMITTED:

9-27-95

16. RETURN TO:

Janet Schalansky, Deputy Secretary  
Kansas Department of Social and Rehabilitation  
Services  
Docking State Office Building  
915 Harrison,  
Topeka, Kansas 66612

## FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

09/28/95

18. DATE APPROVED:

JUN 06 2001

## PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

7/1/95

20. SIGNATURE OF REGIONAL OFFICIAL:

Thomas W. Lenz

21. TYPED NAME:

Thomas W. Lenz

22. TITLE:

ARA for Medicaid

REMARKS:

SPA CONTROL

Date Submitted: 09/27/95

Date Received: 09/28/95

## KANSAS MEDICAID STATE PLAN

Form HCFA-179  
State Plan MS-95-15  
Attachment 4.19D, Part I  
Nursing Facility

### Number of the Plan Section

Assurance Letter Dated September, 1995  
(MS-95-15)

Exhibit C-1, Page 7

Exhibit C-2, Pages 1-6 and 8

Exhibit C-3, Pages 1-3

Exhibit C-4

Exhibit C-5, Pages 1-3

### Number of the Superseded Plan Section

Assurance Letter Dated September 12,  
1995, TN-MS-95-11

Exhibit C-1, Page 7, TN-MS-94-17

Exhibit C-2, Page 5, TN-MS-94-21 and  
Pages 1-4, 6 and 8, TN-MS-94-17

Exhibit C-3, Pages 1-3, TN-MS-94-17

Exhibit C-4, TN-MS-94-17

Exhibit C-5, Pages 1-3, TN-MS-94-17

## KANSAS MEDICAID STATE PLAN

Attachment 4.19D  
Part I  
Subpart C  
Exhibit C-1  
Page 7

### Methods and Standards for Establishing Payment Rates Skilled Nursing and Intermediate Care Facility Rates (NF's and NF's-MH)

#### Narrative Explanation of Nursing Facility Reimbursement Formula

The per diem expenses in each cost center are subject to the 85% minimum occupancy rule for providers reporting costs for the 13th month of operation and after. All previous desk review and field audit adjustments are considered in the per diem expense calculations. The costs are adjusted by the owner/related party/ administrator/co-administrator limitations.

Prior to the Schedule B arrays, the cost data on certain expense lines is adjusted for historical and estimated inflation, where appropriate. This will bring the costs reported by the providers to a common point in time for comparisons. The historic inflation will be based on the Data Resources, Inc. National Skilled Nursing Facility Market Basket Index (DRI Index) for the cost center limits effective July 1st. The historic inflation factor will adjust costs from the midpoint of each providers cost report period to the latest quarterly DRI Index for the Schedule B processing.

The estimated inflation factor will be also be based on the DRI Index. Determination of the estimated inflation factor will begin with the quarter the historic inflation ends. It will be continued to the midpoint of the payment limitation period (December 31st).

Certain costs are exempt from the inflation application when setting the upper payment limits. They include administrators and co-administrator salaries, owner/related party compensation, interest expense, and real and personal property taxes.

The final results of the Schedule B run are the median compilations. These compilations are needed for setting the upper payment limit for each cost center. The median for each cost center is weighted based on total resident days. The upper payment limits will be set using the following:

Administration	115% of the median
Plant Operating (Portion of Property)	130% of the median
Room and Board	130% of the median
Health Care	125% of the median

The overall Property limit requires additional explanation. The implementation of the real and personal property fee (property fee), effective January 1, 1985, revised the method of determining the property limit. Ownership costs (interest, depreciation, lease or amortization of leasehold improvements) are no longer included in the allowable cost when determining the Medicaid rate. The methodology of the overall property limit needed to be revised after the ownership costs were excluded.

Due to the implementation of the property fee, the calculation methodology of the Total Property cost limit has been revised such that changes in ownership (and resulting increases in ownership costs) after 7/18/84 are not recognized in setting new limits. The change in methodology essentially holds the ownership cost portion of the property limit, effective 10/1/84, constant. The revised methodology only allows for relative changes in the plant operating costs to influence the total Property cost limit.

# KANSAS MEDICAID STATE PLAN

Attachment 4.19-D

Part I

Subpart C

Exhibit C-2

Page 1

## INFLATION FOR REPORT YEAR ENDS PRIOR TO 7/1/95 EFFECTIVE 07/01/95

REPORT YEAR END (RYE)	MIDPOINT OF RYE	MIDPOINT OF RYE INDEX	MIDPOINT OF RATE PERIOD	MIDPOINT OF RATE PERIOD INDEX	HISTORICAL INFLATION FACTOR % •
12-93	06-93	1.332	12-95	1.449	8.784%
01-94	07-93	1.345	12-95	1.449	7.732%
02-94	08-93	1.345	12-95	1.449	7.732%
03-94	09-93	1.345	12-95	1.449	7.732%
04-94	10-93	1.359	12-95	1.449	6.623%
05-94	11-93	1.359	12-95	1.449	6.623%
06-94	12-93	1.359	12-95	1.449	6.623%
07-94	01-94	1.372	12-95	1.449	5.612%
08-94	02-94	1.372	12-95	1.449	5.612%
09-94	03-94	1.372	12-95	1.449	5.612%
10-94	04-94	1.378	12-95	1.449	5.152%
11-94	05-94	1.378	12-95	1.449	5.152%
12-94	06-94	1.378	12-95	1.449	5.152%
01-95	07-94	1.389	12-95	1.449	4.320%
02-95	08-94	1.389	12-95	1.449	4.320%
03-95	09-94	1.389	12-95	1.449	4.320%
04-95	10-94	1.400	12-95	1.449	3.500%
05-95	11-94	1.400	12-95	1.449	3.500%
06-95	12-94	1.400	12-95	1.449	3.500%

• = (Midpoint of rate period index / Midpoint of rye index) -1

TN# MS-95-15 Approval Date JUN 06 2001 Effective Date 7/1/95 Supersedes TN# MS-94-17

# KANSAS MEDICAID STATE PLAN

Attachment 4.19-D

Part I

Subpart C

Exhibit C-2

Page 2

## INFLATION FOR REPORT YEAR ENDS AFTER 7/1/95 EFFECTIVE 07/01/95

<u>RYE</u>	<u>MIDPOINT OF RYE</u>	<u># OF MONTHS FROM MIDPOINT TO 07-01-96</u>	<u>RED</u>	<u># OF MONTHS FROM RED TO 07-01-96</u>	<u>INFLATION FACTOR</u>
07-31-95	01-31-95	17	08-01-95	11	3.291%
08-31-95	02-28-95	16	09-01-95	10	3.148%
09-30-95	03-31-95	15	10-01-95	9	3.005%
10-31-95	04-30-95	14	11-01-95	8	2.862%
11-30-95	05-31-95	13	12-01-95	7	2.719%
12-31-95	06-30-95	12	01-01-96	6	2.576%
01-31-96	07-31-95	11	02-01-96	5	2.433%
02-29-96	08-31-95	10	03-01-96	4	2.290%
03-31-96	09-30-95	9	04-01-96	3	2.147%
04-30-96	10-31-95	8	05-01-96	2	2.003%
05-31-96	11-30-95	7	06-01-96	1	1.860%

X = NUMBER OF MONTHS FROM MIDPOINT OF RYE TO 07/01/96

Y = NUMBER OF MONTHS FROM RED TO 07/01/96

FORMULA =  $0.2862\% \cdot [X - (Y/2)]$

ANNUAL RATE OF INFLATION 3.435%

# KANSAS MEDICAID STATE PLAN

Attachment 4.19-D

Part I

Subpart C

Exhibit C-2

Page 3

## COST CENTER LIMITATIONS EFFECTIVE 07/01/95

<u>COST CENTER</u>	<u>UPPER LIMIT</u>
Administration	\$8.74
Property	\$10.27
Room & Board	\$17.63
Health Care	\$42.09 •

• = Base limit for a facility average case mix index of 1.00

# KANSAS MEDICAID STATE PLAN

Attachment 4.19-D

Part I

Subpart C

Exhibit C-2

Page 4

## INCENTIVE FACTORS EFFECTIVE 07/01/95

<u>Level</u>	<u>Percentile Range</u>		<u>Per Patient Day Range</u>		<u>Incentive</u>
	<u>Low</u>	<u>High</u>	<u>Low</u>	<u>High</u>	<u>Factor</u>
NF	-0-	30th	\$ -0-	10.61	\$.50
	31st	55th	10.62	12.71	0.40
	56th	75th	12.72	14.50	0.30
	76th	100th	14.51	above	-0-

## KANSAS MEDICAID STATE PLAN

Attachment 4.19D  
Part I  
Subpart C  
Exhibit C-2  
Page 5

OWNER/RELATED PARTY SALARY LIMITATIONS  
ALL LEVELS OF CARE  
EFFECTIVE 07/01/95

Job Classification	Salary Range	Bed Size: 0-59	60-120	121+	0-99	100	Any Size
Administrator (*)	23E	29,064					
	28E		37,104				
	31E			42,936			
Co-Administrator (*)	19E	23,916					
	22E		27,696				
	24E			30,504			
Accountant (II)	24E						30,504
Attorney (II)	31E						42,936
Bookkeeper	15E						19,680
Secretary (II)	15E						19,680
Gen. Maint. & Repair Tech II	17E						21,696
Physical Plant Supervisor I (1 or 2 Facilities)	23E						29,064
Physical Plant Supervisor II (3 or More Facilities)	25E						32,040
Cook	11E						16,188
Food Service Supervisor II	17E						21,696
Housekeeper/Laundry Worker	9E						14,688
Director of Nursing (RN III *)	25E				32,040		
Director of Nursing (RN IV *)	28E					37,104	
Registered Nurse (RN II *)	22E						27,696
Licensed Practical Nurse (LPN *)	18E						22,776
LPN Supervisor (*)	20E						25,128
Health Care Assistant (Nurse Aides)	12E						17,028
Mental Health Aide	12E						17,028
Physical Therapist II (*)	27E						35,316
Physical Therapist Aide	13E						17,868
Occupational Therapist II (*)	26E						33,660
Speech Path./Audio. I. (*)	26E						33,660
Activity Therapy Tech.	14E						18,744
Activity Therapist I (*)	22E						27,696
Social Worker (*)	22E						27,696
Medical Records Administrator	24E						30,504
Medical Records Technician	19E						23,916
Central Office (3 or More Facilities)							
Chief Executive Officer	36E						54,804
Chief Operating Officer	34E						49,740
All Other Chief Officers	31E						42,936

(\*) License/Registration/Certificate Requirement

TN-MS-95-15 Approval Date JUN 06 2001 Effective Date 7/1/95 Supersedes TN-MS-94-21



# KANSAS MEDICAID STATE PLAN

Attachment 4.19-D

Part I

Subpart C

Exhibit C-2

Page 6

## OWNER/ADMINISTRATOR LIMITATION TABLE EFFECTIVE 07/01/95

Number of Beds	Total Bed Days	Maximum Owner/Admin Compensation	Limit PPD	F/Y	Amount	Cost of Living State Emp.
15	5,490	\$18,591	\$3.39	76	10,000	---
16	5,856	19,377	3.31	77	10280	2.800%
17	6,222	20,163	3.24	78	10537	2.500%
18	6,588	20,949	3.18	79	11301	7.250%
19	6,954	21,735	3.13	80	11781	4.250%
20	7,320	22,521	3.08	81	12617	7.100%
21	7,686	23,307	3.03	82	13248	5.000%
22	8,052	24,094	2.99	83	14109	6.500%
23	8,418	24,880	2.96	84	14426	2.250%
24	8,784	25,666	2.92	85	15147	5.000%
25	9,150	26,452	2.89	86	15933	5.190%
26	9,516	27,238	2.86	87	16411	3.000%
27	9,882	28,024	2.84	88	16575	1.000%
28	10,248	28,810	2.81	89	17238	4.000%
29	10,614	29,597	2.79	90	17755	3.000%
30	10,980	30,383	2.77	91	18021	1.500%
31	11,346	31,169	2.75	92	18021	0.000%
32	11,712	31,955	2.73	93	18111	0.500%
33	12,078	32,741	2.71	94	18202	0.500%
34	12,444	33,527	2.69	95	18407	1.125%
35	12,810	34,313	2.68	96	18591	1.000%
36	13,176	35,100	2.66			
37	13,542	35,886	2.65			
38	13,908	36,672	2.64			
39	14,274	37,458	2.62			
40	14,640	38,244	2.61			
41	15,006	39,030	2.60			
42	15,372	39,816	2.59			
43	15,738	40,603	2.58			
44	16,104	41,389	2.57			
45	16,470	42,175	2.56			
46	16,836	42,961	2.55			
47	17,202	43,747	2.54			
48	17,568	44,533	2.53			
49	17,934	45,319	2.53			
50	18,300	46,106	2.52			

90th Percentile PPD  
Administrator & Co-  
Administrator Salary.

# KANSAS MEDICAID STATE PLAN

Attachment 4.19-D

Part I

Subpart C

Exhibit C-2

Page 8

## CASE MIX INDEX TABLE EFFECTIVE 07/01/95

RUG-III GROUP	CODE	CMI
SPECIAL REHABILITATION		
REHAB VERY HI 14-1	RVC	4.30
REHAB VERY HI 8-13	RVB	3.53
REHAB VERY HI 4-7	RVA	3.37
REHAB HI 15-18	RHD	3.55
REHAB HI 12-14	RHC	2.90
REHAB HI 8-11	RHB	2.88
REHAB HI 4-7	RHA	2.65
REHAB MED 16-18	RMC	2.62
REHAB MED 8-15	RMB	2.16
REHAB MED 4-7	RMA	2.06
REHAB LO 12-18	RLB	1.63
REHAB LO 4-11	RLA	1.47
EXTENSIVE SERVICES		
EXTENSIVE 3	SE3	4.28
EXTENSIVE 2	SE2	2.49
EXTENSIVE 1	SE1	1.69
SPECIAL CARE		
SPECIAL CARE 17-18	SSC	1.52
SPECIAL CARE 14-16	SSB	1.36
SPECIAL CARE 7-13	SSA	1.28
CLINICALLY COMPLEX		
COMPLEX 17-18 D	CD2	1.33
COMPLEX 17-18	CD1	1.27
COMPLEX 11-16 D	CC2	1.19
COMPLEX 11-16	CC1	1.11
COMPLEX 6-10 D	CB2	1.13
COMPLEX 6-10	CB1	1.01
COMPLEX 4-5 D	CA2	0.99
COMPLEX 4-5	CA1	0.82

RUG-III GROUP	CODE	CMI
IMPAIRED COGNITION		
IMPAIRED 6-10 N	IB2	0.98
IMPAIRED 6-10	IB1	0.89
IMPAIRED 4-5 N	IA2	0.79
IMPAIRED 4-5	IA1	0.67
BEHAVIOR PROBLEMS		
BEHAVIOR 6-10 N	BB2	1.00
BEHAVIOR 6-10	BB1	0.88
BEHAVIOR 4-5 N	BA2	0.70
BEHAVIOR 4-5	BA1	0.62
REDUCED PHYSICAL FUNCTIONS		
PHYSICAL 16-18 N	PE2	1.08
PHYSICAL 16-18	PE1	1.03
PHYSICAL 11-15N	PD2	1.02
PHYSICAL 11-15	PD1	0.97
PHYSICAL 9-10 N	PC2	0.91
PHYSICAL 9-10	PC1	0.91
PHYSICAL 6-8 N	PB2	0.81
PHYSICAL 6-8	PB1	0.72
PHYSICAL 4-5 N	PA2	0.72
PHYSICAL 4-5	PA1	0.58

# KANSAS MEDICAID STATE PLAN

Attachment 4.19-D

Part I

Subpart C

Exhibit C-3

Page 1

## COMPILATION OF COST CENTER LIMITATIONS EFFECTIVE 07/01/95

	***BEFORE INFLATION***					***AFTER INFLATION***						
	ADMIN	PLT	OP	RM&BRD	HLTCR	TOTAL	ADMIN	PLT	OP	RM&BRD	HLTCR	TOTAL
MEDIAN	7.33	4.74		12.91	31.95	56.90	7.60	4.96		13.56	33.67	59.67
MEAN	7.78	5.14		13.90	32.94	59.75	8.08	5.39		14.62	34.65	62.73
WTMN	7.56	5.02		13.60	32.81	58.99	7.85	5.26		14.31	34.52	61.94
# OF PROV	389						389					

# KANSAS MEDICAID STATE PLAN

Attachment 4.19-D  
Part I  
Subpart C  
Exhibit C-3  
Page 2

## COMPILATION OF ADMINISTRATOR, CO-ADMINISTRATOR AND OWNER EXPENSE - O/A LIMIT

	ADMINISTRATOR		CO-ADMINISTRATOR		TOTAL ADMN & CO-ADMN		OWNER	
	TOTAL	PRD	TOTAL	PRD	TOTAL	PRD	TOTAL	PRD
HIGH	97,920	6.61	41,055	1.70	97,920	6.61	293,204	7.23
99th	72,414	4.02	41,055	1.70	79,449	4.02	153,021	5.73
95th	54,022	2.72	33,426	1.59	55,251	2.75	82,130	2.97
90th	48,597	2.47	32,524	1.07	48,950	2.52	58,296	2.25
85th	45,499	2.32	25,029	0.83	45,712	2.33	45,760	2.01
80th	43,380	2.17	24,391	0.74	44,126	2.21	34,705	1.30
75th	41,323	2.06	23,745	0.71	41,681	2.09	21,259	0.92
70th	39,889	1.96	16,295	0.64	40,143	1.98	19,992	0.79
65th	38,672	1.89	15,747	0.62	38,892	1.92	15,472	0.70
60th	37,425	1.84	11,703	0.53	37,835	1.86	12,637	0.62
55th	36,186	1.76	9,931	0.51	36,480	1.78	11,507	0.58
50th	35,443	1.67	8,277	0.26	35,496	1.71	9,808	0.48
40th	33,506	1.51	5,269	0.19	33,981	1.56	6,724	0.34
30th	30,455	1.38	3,868	0.18	30,679	1.40	4,244	0.25
20th	27,209	1.21	1,736	0.05	27,286	1.21	1,818	0.07
10th	20,280	1.04	1,172	0.04	20,280	1.05	1,106	0.04
1st	5,865	0.51	632	0.03	5,865	0.43	86	0.00
LOW	1,622	0.03	632	0.03	2,320	0.07	-19,936	-4.09
MEAN	35,242	1.74	12,911	0.49	35,920	1.76	21,217	0.85
WTMN	38,154	1.59	14,223	0.44	39,129	1.61	25,742	0.88
of Prov	359		30		363		193	

TN# MS-95-15 Approval Date JUN 06 2001 Effective Date 7/1/95 Supersedes TN# MS-94-17

# KANSAS MEDICAID STATE PLAN

Attachment 4.19-D

Part I

Subpart C

Exhibit C-3

Page 3

## COMPILATION OF LINE ITEM INPUTS TO INCENTIVE FACTOR

	INCENTIVE AMOUNT
HIGH	77.13
99th	54.83
95th	19.77
90th	17.56
85th	16.23
80th	15.16
75th	14.50
70th	13.94
65th	13.54
60th	13.18
55th	12.71
50th	12.41
40th	11.36
30th	10.61
20th	9.67
10th	8.90
1st	6.95
LOW	6.36
MEAN	13.36
WTMN	12.71
# of Prov	384

TN# MS-95-15 Approval Date JUN 06 2001 Effective Date 7/1/95 Supersedes TN# MS-94-17

# KANSAS MEDICAID STATE PLAN

Attachment 4.19-D

Part I

Subpart C

Exhibit C-4

BILL GRAVES, GOVERNOR OF THE STATE OF KANSAS



## KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

915 SW HARRISON STREET, TOPEKA, KANSAS 66612

ROCHELLE CHRONISTER, SECRETARY

June 26, 1995

Dear Administrator:

We forwarded the per diem rate shown on the attached Case Mix Payment Schedule for 1st Quarter FY 96 (computer print-out) to our fiscal agent, EDS-Federal. The rate is effective July 1, 1995. The payment schedule and rate reflect the revised cost center limitations, inflation factors, owner/related party/administrator compensation per diem limitations, incentive ranges and the full case mix adjustment in the Health Care cost center.

SRS determined this rate by applying the appropriate Medicaid program policies and regulations to the cost report (Form MS 2004) data shown on the enclosed payment schedule. Desk review adjustments to the cost report are shown on the enclosed Provider Adjustment Sheet, except transfers from one line to another, which are shown in the "Reason for SRS Adjustments" column of the schedule. (All related transfers in this column have the same key number.) IF YOU HAVE ANY QUESTIONS ABOUT ANY DESK REVIEW ADJUSTMENT, CALL THE ADULT CARE HOME PROGRAM'S AUDIT MANAGER IN SRS AUDIT SERVICES AT (913) 296-3836.

THE FACILITY'S RATE FOR NON MEDICAID/MEDIKAN RESIDENTS MUST EQUAL OR EXCEED THE MEDICAID/MEDIKAN RATE FOR COMPARABLE CARE AND SERVICES. If the private pay rate indicated on the agency register is lower, then the Medicaid/Medikan rate, beginning with its effective date, shall be lowered to the private pay rate reflected on the registry. Providers who subsequently notify the agency by certified mail of the private pay rate shall have the Medicaid/Medikan rate adjusted the first day of the month following the date of the certified letter. SEE KANSAS ADMINISTRATIVE REGULATION (KAR) 30-10-18(b).

If you do not agree with this action, you have the right to request a fair hearing appeal in accordance with K.A.R. 30-7-64 et seq. Your written request for such an appeal should be delivered to or otherwise mailed so that it is received by the SRS Administrative Hearings Section, 2nd Floor, 610 West Tenth, Topeka, Kansas 66612 within 30 days from the date of this letter. (Pursuant to K.S.A. 77-531, an additional three days shall be allowed if this notice letter is mailed rather than hand delivered.) Failure to timely request or pursue such an appeal may adversely affect your rights on any related judicial review proceeding.

If you have questions regarding the Medicaid rate, other than those on desk review adjustments, write to me or call at (913) 296-0703.

Sincerely,

A handwritten signature in cursive script that reads "Bill McDaniel".

Bill McDaniel, Administrator  
Nursing Facility Reimbursement  
Medical Services/Fiscal Unit

BRM:ckc  
Enclosures

JUN 06 2001

TN# MS-95-15 Approval Date \_\_\_\_\_ Effective Date 7/1/95 Supersedes TN# MS-94-17

# KANSAS MEDICAID STATE PLAN

Attachment 4.19-D

Part I

Subpart C

Exhibit C-5

Page 1

0620952403210011

STATE OF KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES  
DIVISION OF MEDICAL SERVICES - MEDICAID ADULT CARE HOME COST ANALYSIS

CASE MIX SCHEDULE  
1ST QRT 1996  
PAGE 1

123456789012345678901234

## \*\*\*\*\* PROVIDER INFORMATION \*\*\*\*\*

PROVIDER NO.....				
FACILITY NAME.....	BEDS AVAILABLE	PRIOR	CURRENT	%CHG
ADDRESS.....	NURSING FACILITY.....	43	58	34.9
CITY/STATE/ZIP....	NF-MENTAL HEALTH.....	0	0	0.0
ADMINISTRATOR.....	OTHER.....	0	0	0.0
	TOTAL.....	43	58	34.9
REPORT YEAR END... 12/31/94	BED DAYS AVAILABLE...	15,695	17,525	11.7
FISCAL YEAR END... 12/31/94	INPATIENT DAYS.....	15,510	15,392	-0.8
	OCCUPANCY RATE.....	98.8	87.8	-11.1
INFLATION FACTOR.. 5.152	MEDICAID DAYS.....	7,025	7,913	12.6
	CAL DAYS JF APPL.....	0	0	
CMI..... 1.01	RES DAYS USED IN DIV.	15,510	15,392	

## \*\*\*\*\* RECAP OF RESIDENT RELATED EXPENSES AND RATE CALCULATION \*\*\*\*\*

	ADMIN	PLANT OPERATING	ROOM & BOARD	HEALTH CARE	TOTAL
RES RELATED EXP.....	115,970	101,247	297,911	655,595	1,170,723
COST PER RESIDENT DAY....	7.53	6.58	19.35	42.59	76.05
INFLATION.....	0.26	0.34	1.00	2.19	3.79
PPD COST BEFORE LIMITS...	7.79	6.92	20.35	44.78	79.84
PPD COST LIMITS.....NF	8.74	4.12	17.63	42.51	73.00
ALLOWED COST.....	7.79	4.12	17.63	42.51	72.05

NF

ALLOWED COST.....	72.05
INCENTIVE FACTOR.....	0.30
REAL AND PERSONAL PROPERTY FEE.....	6.15
24-HR NURSING ADJUSTMENT.....	0.00
PER RESIDENT DAY RATE EFFECTIVE.....	07/01/95 78.50
PRIVATE PAY RATE.....	09/01/94 72.00

TN# MS-95-15 Approval Date JUN 06 2001 Effective Date 7/1/95 Supersedes TN# MS-94-17

## KANSAS MEDICAID STATE PLAN

Attachment 4.19-D

Part I

Subpart C

Exhibit C-5

Page2

PAGE 2

## \*\*\*\*\* EXPENSE STATEMENT \*\*\*\*\*

DESCRIPTION	LINE NO.	REPORTED EXPENSE	PROVIDER ADJUSTMT	CURRENT YEAR SRS ADJUSTMT	RESIDENT EXPENSE	PER DAY	* PRIOR YEAR * RESIDENT EXPENSE	PER DAY	% CHG	LINE NO.	REASON FOR SRS ADJUSTMENT
<b>ADMINISTRATION</b>											
SALARY-ADMIN	101	61,489	-22,200	0	39,289	2.55	30,034	1.94	31.44	101	
SALARY-CO ADM	102	0	0	0	0	0.00	0	0.00	0.00	102	
OTHER ADM SAL	103	0	22,200	0	22,200	1.44	18,956	1.22	18.03	103	
EMP BENEFITS	104	10,925	0	-251	10,674	0.69	9,925	0.64	7.81	104	Note Attached
OFC SUP & PRINT	105	9,370	0	-217	9,153	0.59	2,245	0.14	321.43	105	Note Attached
MGT CONSULTING	106	575	0	0	575	0.04	0	0.00	100.00	106	
OWN/REL PTY CMP	107	0	0	0	0	0.00	0	0.00	0.00	107	
CENTRAL OFC	108	0	0	0	0	0.00	0	0.00	0.00	108	
PHONE & COMMUNI	109	2,267	0	-255	2,012	0.13	3,104	0.20	-35.00	109	Note Attached
TRAVEL	110	933	0	1,331	2,264	0.15	481	0.03	400.00	110	Note Attached
ADVERTISING	111	1,510	0	284	1,794	0.12	0	0.00	100.00	111	Note Attached
LICENSES & DUES	112	2,834	0	0	2,834	0.18	2,024	0.13	38.46	112	
LEGAL/ACCTG DP	113	7,967	0	0	7,967	0.52	8,176	0.53	-1.89	113	
INS EXCEPT LIFE	114	19,475	-2,187	0	17,288	1.12	15,178	0.98	0.00	114	
INT EXCEPT R/E	115	0	0	0	0	0.00	0	0.00	0.00	115	
OTHER	117	421	0	0	421	0.03	1,157	0.07	-57.14	117	
OTHER	118	1,978	0	-1,978	0	0.00	3,636	0.23	0.00	118	Note Attached
O/A LIMIT	119	0	0	-501	-501	-0.03	0	0.00	100.00	119	
TOTAL ADMIN	120	119,744	-2,187	-1,587	115,970	7.53	94,916	6.12	23.04	120	
<b>PLANT OPERATING</b>											
R/E & PP TAXES	121	0	0	0	0	0.00	0	0.00	0.00	121	
SALARIES	126	33,839	0	0	33,839	2.20	32,589	2.10	4.76	126	
EMP BENEFITS	127	6,012	0	-141	5,871	0.38	6,602	0.43	-11.63	127	Note Attached
OWN/REL PTY CMP	128	0	0	0	0	0.00	0	0.00	0.00	128	
UTILITIES	129	38,579	0	0	38,579	2.51	36,705	2.37	5.91	129	
MAINT & REPAIR	130	17,512	0	0	17,512	1.14	15,221	0.98	16.33	130	
SUPPLIES	131	1,572	0	0	1,572	0.10	2,042	0.13	-23.08	131	
SMALL EQUIPMENT	137	2,035	0	1,583	3,618	0.24	0	0.00	100.00	137	Note Attached
OTHER	138	419	0	-163	256	0.02	231	0.01	100.00	138	Note Attached
TOTAL PLANT OP	139	99,968	0	1,279	101,247	6.58	93,390	6.02	9.30	139	
<b>ROOM &amp; BOARD</b>											
EMP BENEFITS	141	32,613	0	-749	31,864	2.07	34,351	2.21	-6.33	141	Note Attached
DIETARY-SAL	142	147,390	0	0	147,390	9.58	132,753	8.56	11.92	142	
OWN/REL PTY CMP	143	0	0	0	0	0.00	0	0.00	0.00	143	
CONSULTANT	144	0	0	0	0	0.00	0	0.00	0.00	144	
FOOD	145	60,516	0	0	60,516	3.93	61,499	3.97	-1.01	145	
SUPPLIES	146	9,558	0	0	9,558	0.62	8,012	0.52	19.23	146	
OTHER	148	513	0	0	513	0.03	1,929	0.12	-75.00	148	
LAUNDRY-LINEN-SAL	149	30,135	0	0	30,135	1.96	32,360	2.09	-6.22	149	
LINEN - BEDDING	150	7,253	0	0	7,253	0.47	4,690	0.30	56.67	150	
SUPPLIES	151	3,641	0	0	3,641	0.24	4,412	0.28	-14.29	151	
OTHER	153	0	0	0	0	0.00	0	0.00	0.00	153	
HOUSEKEEPING-SAL	154	6,028	0	0	6,028	0.39	4,433	0.29	34.48	154	
SUPPLIES	155	1,013	0	0	1,013	0.07	853	0.05	40.00	155	
OTHER	158	0	0	0	0	0.00	0	0.00	0.00	158	
TOTAL RM & BOARD	159	298,660	0	-749	297,911	19.35	285,292	18.39	5.22	159	

TN# MS-95-15 Approval Date JUN 06 2001 Effective Date 7/1/95 Supersedes TN# MS-94-17



## KANSAS MEDICAID STATE PLAN

Attachment 4.19-D

Part I

Subpart C

Exhibit C-5

Page 3

PAGE 3

## \*\*\*\*\* EXPENSE STATEMENT \*\*\*\*\*

DESCRIPTION	LINE NO.	REPORTED EXPENSE	PROVIDER ADJUSTMT	CURRENT YEAR SRS ADJUSTMT	RESIDENT EXPENSE	PER DAY	* PRIOR YEAR * RESIDENT EXPENSE	PER DAY	% CHG	LINE NO.	REASON FOR SRS ADJUSTMENT
<b>HEALTH CARE</b>											
NURSING-RN	161	68,487	0	0	68,487	4.45	49,042	3.16	40.82	161	
LPN/LMHT	162a	76,109	0	0	76,109	4.94	99,044	6.39	-22.69	162a	
LPN/LMHT	162b	0	0	0	0	0.00	0	0.00	0.00	162b	
OTHER NURSING	163a	336,148	0	0	336,148	21.84	290,508	18.73	16.60	163a	
OTHER NURSING	163b	0	0	0	0	0.00	0	0.00	0.00	163b	
OTHER NURSING	163c	0	0	0	0	0.00	0	0.00	0.00	163c	
EMP BENEFITS	164	92,956	0	1,141	94,097	6.11	95,880	6.18	-1.13	164	Note Attached
OWN/REL PTY CMP	165	0	0	0	0	0.00	0	0.00	0.00	165	
CONSULTANTS	166	0	0	0	0	0.00	0	0.00	0.00	166	
PURCH SERVICES	167	0	0	0	0	0.00	0	0.00	0.00	167	
SUPPLIES	168	9,785	0	0	9,785	0.64	8,361	0.54	18.52	168	
OTHER	170	3,417	0	-1,168	2,249	0.15	0	0.00	100.00	170	Note Attached
THPY/OTHER SAL	171a	15,038	0	0	15,038	0.98	11,674	0.75	30.67	171a	
THPY/OTHER SAL	171b	0	0	0	0	0.00	0	0.00	0.00	171b	
THPY/OTHER SAL	171c	0	0	0	0	0.00	0	0.00	0.00	171c	
THPY/OTHER SAL	171d	0	0	0	0	0.00	0	0.00	0.00	171d	
THPY/OTHER SAL	171e	0	0	0	0	0.00	0	0.00	0.00	171e	
THPY/OTHER SAL	171f	0	0	0	0	0.00	0	0.00	0.00	171f	
OWN/REL PTY CMP	172	0	0	0	0	0.00	0	0.00	0.00	172	
PAT ACT/SOC WKR	173a	15,941	0	0	15,941	1.04	15,975	1.03	0.97	173a	
PAT ACT/SOC WKR	173b	11,464	0	0	11,464	0.74	6,470	0.42	76.19	173b	
PAT ACT/SOC WKR	173c	18,852	0	0	18,852	1.22	0	0.00	100.00	173c	
PAT ACT/SOC WKR	173d	0	0	0	0	0.00	520	0.03	0.00	173d	
PAT ACT SUPPLS	174	2,894	-1,250	0	1,644	0.11	1,739	0.11	0.00	174	
OCCUP THERAPY	175	0	0	0	0	0.00	0	0.00	0.00	175	
MED RECORDS-COM	176	1,643	0	0	1,643	0.11	0	0.00	100.00	176	
PHARM-CONSULTANTS	177	0	0	0	0	0.00	0	0.00	0.00	177	
SPEECH THERAPY	178	0	0	0	0	0.00	0	0.00	0.00	178	
PHYSICAL THERAPY	179	0	0	0	0	0.00	0	0.00	0.00	179	
CONSULTANT	180	81	1,250	0	1,331	0.09	702	0.05	80.00	180	
NURSING TRNG	181a	2,807	0	0	2,807	0.18	1,242	0.08	125.00	181a	
NURSING TRNG	181b	303	0	-303	0	0.00	0	0.00	0.00	181b	Note Attached
RESIDENT TRANSP	182	0	0	0	0	0.00	1,284	0.08	0.00	182	
OTHER	183	0	0	0	0	0.00	0	0.00	0.00	183	
OTHER	188	0	0	0	0	0.00	0	0.00	0.00	188	
TOTAL HLTH CARE	189	655,925	0	-330	655,595	42.59	582,441	37.55	13.42	189	
TOTAL ALLOWABLE	190	1,174,297	-2,187	-1,387	1,170,723	76.05	1,056,039	68.08	11.71	190	
<b>OWNERSHIP</b>											
INT-R/E MORTG	191	0	0	0	0	0.00	576	0.04	0.00	191	
RENT/LEASE	192	7,534	0	-330	7,204	0.47	7,750	0.50	-6.00	192	Note Attached
LEASEHOLD IMPRV	193	0	0	0	0	0.00	0	0.00	0.00	193	
DEPRECIATION	194	79,265	0	0	79,265	5.15	50,567	3.26	57.98	194	
TOTAL OWNERS	195	86,799	0	-330	86,469	5.62	58,893	3.80	38.92		

## REAL AND PERSONAL PROPERTY FEE COMPONENT

EFF DATE	RES DAYS	MTG INT	RENT/LEASE	AMORT	DEPR	TOTAL	PPD	PROP ALLOW	VALUE FACTOR	PROP FEE
09/01/94	15,392	3,343	0	0	86,973	90,316	5.87	6.15	0.00	6.15

TN# MS-95-15 Approval Date JUN 06 2001 Effective Date 7/1/95 Supersedes TN# MS-94-17



KANSAS DEPARTMENT OF SOCIAL  
AND REHABILITATION SERVICES

915 SW HARRISON STREET, TOPEKA, KANSAS 66612

ROCHELLE CHRONISTER, SECRETARY

September 27, 1995

Mr. Richard P. Brummel  
Associate Regional Administrator for the  
Division of Medicaid  
Room 235, Federal Office Building  
601 East 12th Street  
Kansas City, Missouri 64106

Dear Mr. Brummel:

In accordance with 42 CFR 447.253, the Kansas Department of Social and Rehabilitation Services submits the following assurances related to Kansas Medicaid payment for long term care services in nursing facilities (NFs) and NFs-Mental Health (MH). The requirements set forth in paragraphs (b) through (i) of this section are being met. The related information required by section 447.255 of this subpart is furnished herewith and the agency complies with all other requirements.

**42 CFR 447.253(b) Findings**

The State of Kansas, through this agency does make findings to ensure that the rates used to reimburse providers satisfy the requirements of paragraph 447.253(b).

**42 CFR 447.253(b)(1)(i) Payment Rates**

The State of Kansas continues to pay NFs and NFs-MH for long term care services in accordance with a state plan formula established through consultation with representatives of the corresponding provider groups. The rates are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

**42 CFR 447.253(b)(1)(iii) Payment Rates**

With respect to NF and NF-MH services, the State of Kansas assures that:

(A) Except for preadmission screening for individuals with mental illness and mental retardation under 42 CFR 483.20(f), the methods and standards used to determine payment rates take into account the cost of complying with Part 483, Subpart B of Chapter IV;

Refers to MS-95-15

ARP  
JUN 06 2001

(B) The methods and standards used to determine payment rates provide for an appropriate reduction to take into account the lower costs (if any) of the facility for nursing care under a waiver of the requirement in 42 CFR 483.30(c) of Chapter IV to provide licensed nurses on a 24-hour basis;

(C) The State of Kansas established procedures under which the data and methodology used in establishing payment rates are made available to the public.

#### **42 CFR 447.253(b)(2) Upper Payment Limits**

The State of Kansas assures that the estimated average proposed Medicaid payment is reasonably expected to pay no more in the aggregate for NF and NF-MH services than the amount the agency reasonably estimates would be paid under the Medicare principles of reimbursement. There are no state operated NFs or NFs-MH so 447.272(b) does not apply.

#### **42 CFR 447.253(d) Changes in Ownership of NFs and ICFs-MR**

The State of Kansas assures that its NFs and NFs-MH payment methodology is not reasonably expected to result in an increase in aggregate payments based solely as the result of a change in ownership in excess of the increase that would result from application of 447.253(d)(1) and (2).

#### **42 CFR 447.253(e) Provider Appeals**

The State of Kansas, in accordance with federal regulations and with the Kansas Administrative Regulations, provides a fair hearing, appeal or exception procedure that allows for an administrative review and appeal by the provider as to their payment rates.

#### **42 CFR 447.253(f) Uniform Cost Reporting**

Nursing facility and NF-MH providers are required to file annual uniform cost reports in accordance with Kansas Administrative Regulations and Attachment 4.19D, Part I, Methods and Standards for Establishing Payment Rates.

#### **42 CFR 447.253(g) Audit Requirements**

The State of Kansas performs a review on all cost reports within six months of receipt and provides for periodic field audits of the financial and statistical records of the participating providers.

#### **42 CFR 447.253(h) Public Notice**

In accordance with 42 CFR 447.205, public notice is given for the significant changes proposed to the methods and standards for setting NF and NF-MH payment rates.

Refers to MS-95-15

Mr. Richard P. Brummel  
Page Three

#### 42 CFR 447.253(i) Rates Paid

The State of Kansas assures that payment rates are determined in accordance with methods and standards specified in an approved State Plan.

#### 42 CFR 447.255 Related Information

Estimated Average NF/NF-MH Rate:	7/1/95	\$63.68
Estimated Average NF/NF-MH Rate:	4/1/95	\$60.08
Per Diem Increase		3.60
Average Percent Increase		5.99%

Both the short-term and long-term effect of these changes are estimated to:

1. Maintain the availability of services on a statewide and geographic area basis.


There are approximately 406 licensed NFs or NFs-MH in the State of Kansas with at least one in every county. Of these, 399 or 98% are certified to participate in the Medicaid Program. There are 15 licensed NFs-MH in the State of Kansas and all of them participate in the Medicaid program. Beds are available in every area of the State and close coordination with the local and area SRS offices allows the agency to keep close track of vacancies;

2. Maintain the type of care furnished; and
3. Maintain the extent of provider participation.

The extent of provider participation should not be affected by this change. Ninety-eight percent of the available providers are already participating in the program.

Any questions regarding this Plan submission should be directed to Marti Malcolm or Bill McDaniel at (913) 296-3981.

Sincerely,

  
Janet Schalansky  
Deputy Secretary

JS:AEK:mas

Refers to MS-95-15